

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33206

FILED SEP 23 1957

STATE FILE NUMBER
8552

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5240 Chippewa			Length of stay in 1b		d. STREET ADDRESS 5240 Chippewa		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Harvey G Bauer				4. DATE OF DEATH Month Day Year Sept 10 1957				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 7, 1907		
9. AGE (In years last birthday) 50		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? USA		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) butcher				10b. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME William Bauer		
14. MOTHER'S MAIDEN NAME Ella-----				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW-2				
16. SOCIAL SECURITY NO.				17. INFORMANT Mary Dellevadova 5240 Chippewa				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Carcinoma with General Metastasis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 163x							INTERVAL BETWEEN ONSET AND DEATH 3 Mo.	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)						
20e. CITY, TOWN, OR LOCATION		COUNTY		STATE				
21. I attended the deceased from June 20th 1957 to Sept. 10th 1957 and last saw her alive on Sept. 9th 1957 Death occurred at 11:45p m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) V. H. Walters M.D.				22b. ADDRESS 3608 South Grand Blvd.,		22c. DATE SIGNED 9/11/57		
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 9/13/1957		23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.		
24. FUNERAL DIRECTOR J L Ziegenhein & Sons 7027 Gravois				25. DATE RECD. BY LOCAL REG. SEP 12 '57		26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.		

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No. _____ working under my personal supervision..

Student _____
Signature of Student Embalmer

Signed C. P. Kidwell
Licensed Embalmer No. 387

P. O. Address 7027 Grace

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.